Flexible Spending Account Plans

2013

- Health Care
- Dependent Care

City of Seattle

City of Seattle

Flexible Spending Account Plans

The City of Seattle Flexible Spending Account (FSA) Plans allow you to set aside pretax dollars from your paycheck to pay for certain expenses not covered through your other benefits. When you put money into an FSA you do not pay federal or FICA (Social Security) taxes on it. As a result, your taxable income is reduced and your taxes are lower.

The City of Seattle offers two types of FSA Plans:

- **Health Care FSA** allows you to set aside pretax dollars to pay for certain expenses not covered by your health plans (for example, the cost of orthodontia not fully paid by your dental plan and copays for office visits).

- **Dependent Care FSA** allows you to set aside pretax dollars to pay for eligible dependent care expenses for your child, disabled spouse or dependent parent while you and your spouse work.

This guide explains how Health Care and Dependent Care FSAs work. If you decide to enroll, you must complete your online enrollment:

- Within 31 days of becoming a City employee.
- During the open enrollment period if you wish to enroll or re-enroll for next year.
- Within 31 days of a qualifying change in family status.

For additional information go to the City of Seattle web site at personnelweb/benefits/home.aspx , or contact your department's human resource representative.

You must re-enroll each year at Open Enrollment to continue participating in Flexible Spending Accounts.

Table of Contents Page

HOW FSAs WORK

- Flexible Spending Accounts (FSAs) allow employees to have income withheld from their paychecks *before federal or Social Security taxes are assessed*, to use for reimbursement of certain medical and dependent care expenses. As a result, your taxable income is reduced and you pay less in taxes, saving you money.

- You decide how much you want to contribute to the Health Care and/or Dependent Care Flexible Spending Account each year. You must use your FSA money or you lose it.

- **You must re-enroll each year during Open Enrollment to continue participating;** you may change the amount you contribute.

- You enroll by completing the Open Enrollment section on Employee Self Service during Open Enrollment or the New Hire Module on Employee Self Service if you are a new employee. By enrolling, you are authorizing the City of Seattle to deduct a certain portion of your salary each pay period on a pretax basis. These contributions are then placed into your account(s) throughout the calendar/plan year via payroll deduction. Flex-Plan Services administers the accounts for the City of Seattle.

- **The benefits plan year is the calendar year**. You may submit reimbursement requests for expenses incurred during the plan year any time throughout the plan year and up until March 31 of the following year (requests must be received by Flex-Plan Services no later than March 31).

- As you incur eligible expenses, you may submit reimbursement request forms to Flex-Plan Services. You may submit multiple bills or receipts with one reimbursement request form. Include a copy of an itemized bill(s) or receipt(s) with the completed reimbursement form. Completed requests for reimbursements may be mailed, faxed or uploaded at the FPS website, or through the mobile app:

  Flex-Plan Services, Inc.
  PO Box 53250
  Bellevue, WA 98015-3250
  Phone: 425-451-7002 or 800-669-FLEX
  Fax 425-451-7002 or 866-535-9227
  www.flex-plan.com

- FSAs are governed by the Internal Revenue Service Code. For details on current rules, see the following documents posted on www.irs.gov.
  - Publication 502: Medical and Dental Expenses
  - Publication 503: Child and Dependent Care Expenses
  - Publication 969: Health Savings Accounts and Other Tax-Favored Health Plans

GENERAL RESTRICTIONS

- Under the City plan, the maximum that can be contributed to the Health Care FSA is $2,500.00 per year. The maximum amount that can be contributed to the Dependent Care FSA is $5,000.00 per year if married filing a joint return or head-of-household; $2,500.00 if married filing separately. The minimum that can be contributed to either FSA is $300.00 annually.
- Health Care and Dependent Care FSA are completely separate. The money you allocate for one cannot be used for the other and you cannot transfer dollars between accounts.

- You must use the FSA money or you lose it. **Any money left in your FSA account that is not reimbursed to you by March 31 of the following year is forfeited**, so it is important to estimate annual expenses carefully before enrolling and set aside only as much as you expect to spend.

- You cannot make a change to your Health Care or Dependent Care FSA contributions during the plan year unless you experience a qualifying status change (see page 13). You may terminate your participation during the plan year if you experience a qualifying status change. However, health care expenses you incur after the termination date **will not be eligible** for reimbursement even if you still have an account balance remaining. Dependent care expenses allowing you to work, seek work, or attend school full-time that are incurred after termination will be eligible for reimbursement.

- Expenses for eligible services incurred during the plan year are reimbursed from that year's FSA. You have until March 31 of the following year to file reimbursement requests (Your request must be received by Flex-Plan Services no later than March 31.)

- You cannot use a Health Care FSA to pay expenses you also claim as health care deductions on your income tax return. Similarly, you may not use the Dependent care FSA to claim expenses that you will use to take the childcare tax credit on your return.

EFFECT ON OTHER BENEFITS

FSA contributions may affect Social Security benefits. Because you and the City do not pay Social Security (FICA) taxes on the money you contribute, your future Social Security benefits may be reduced slightly. However, you may find that the tax savings gained through participation in an FSA outweigh any loss in benefits. Contact your tax advisor for help deciding whether or not an FSA is right for you.

If you contribute to the Dependent Care FSA, your maximum allowed contribution to the City of Seattle Deferred Compensation Plan could be reduced to lower gross earning. There is no effect on your other City benefits, such as life insurance or retirement.

Nondiscrimination testing may affect your contributions. Nondiscrimination testing is conducted to ensure that the plan does not favor highly compensated employees. If the City fails nondiscrimination testing, highly compensated employees may be asked to limit or stop their contributions to the program.

HOW YOU CAN ENROLL

You can enroll in the FSA plans as a new employee or during Open Enrollment via the Employee Self-Service module available from any computer.

To complete your enrollment online if you are a new employee, you will be given instructions from your human resources representative. You will have access to the New Hire Module on Employee Self-Service for 31 days from your hire date.

To complete your enrollment online during Open Enrollment:

1. **GO** to Employee Self-Service at wald1.seattle.gov/dea/hris/LogOn/LogOn/ .
2. **ENTER your employee number and password** (if you do not know your employee number, contact your HR rep. For a password reset contact DoIT or the appropriate department contact.)
3. **SELECT** *Benefits* and then *Open Enrollment*
   *(If this is your first time opening the benefits enrollment, please review the OpenEnrollment agreement and **select agree**.)*
4. **CHOOSE** *Health FSA Plan* and/or *Dependant Care FSA Plan*
5. **STEP 1 - CHECK** *Enroll / Re-enroll*
   STEP 2 - ENTER * MONTHLY amount **see note in ESS*
   STEP 3 - SAVE your changes. The following message will appear : [Successfully Changed]
6. To confirm 2013 benefit changes **SELECT Summary of Election**
7. **PRINT** a copy for your records

FSA ONLINE ACCOUNT

You can review your account, upload claims directly, upload requested receipts, and update personal information when you sign up for an online account. To set up an account:

- Provide FPS with your email address by submitting the Direct Deposit/Benny Card Authorization form, submitting a claim form, or calling Customer Service.
- Go to www.flex-plan.com.
- Select the "Participant" link to direct you to the participant information page.
- Select "Register with Flex-Plan.com".
- Enter your last name, first initial.
- Enter the email address you provided to FPS previously.
- Enter the Company Code: CS1
- Choose a User Name.
- Enter your date of birth.

Do not forget to review and accept the Terms and Conditions. Shortly after registering for online access, you will receive an email confirmation with a temporary password. You will need to reset the password upon your first login.

FUTURE OF THE FSA PLANS

The City of Seattle has established the Flexible Spending Account Plan with the intention that it will be maintained indefinitely; however, the City reserves the right to alter, amend, delete, cancel, or otherwise change the plan or any provision of the plan at anytime.

HEALTH CARE FLEXIBLE SPENDING ACCOUNT

If you are a regularly appointed full-time or part-time employee and have eligible health care expenses, including medical, dental and vision, you are eligible to participate. Expenses for your eligible dependents are also covered by the plan, including domestic partner if you claim him or her as your IRS tax dependent.

HEALTH CARE FSA vs. ITEMIZED TAX DEDUCTION

You may use a Health Care FSA to pay for any health care expenses considered tax deductible by the IRS, but you also have the option of taking a federal income tax deduction for health care expenses if your eligible expenses exceed 7.5% of your adjusted gross income (AGI). Your contributions to the Health Care FSA do not count toward reaching the 7.5% AGI threshold. In other words, you may not take a tax deduction for the same expenses that are reimbursed from a Health Care FSA. For most people, the Health Care FSA makes the most sense and offers you significant income tax savings throughout the calendar year. Please see a tax advisor for advice on your personal situation.

SAVINGS EXAMPLE

The following example shows how the Health Care FSA can provide a tax advantage. The example is for illustration only and is not intended to show the actual effect on your taxes. Each individual's tax situation is different and you should discuss your situation with your personal tax advisor.

When you decide whether to participate in the Plan, you should consider your expected income and health care expenses for 2013, the possibility of changes in those amounts, and the "use it or lose it" rule as explained on page 5. Also, consider whether you will use the standard deduction or itemize your deductions. The following compares two employees with the same gross pay and medical costs; one has a Flexible Spending Account and the other does not. Employee B saves $540 a year in taxes.

Employee A – Without FSA		Employee B – With FSA	
$35,000	Gross Pay	$35,000	Gross Pay
-7,093	Taxes	-2,400	Medical Costs
$27,907		$32,600	
-2,400	Medical Costs	-6,549	Taxes
$25,507	Net Pay	$26,051	Net Pay
$2,126	**Monthly Pay**	**$2,171**	**Monthly Pay**

ELIGIBLE HEALTH CARE EXPENSES

Following is a partial list of health care expenses eligible for reimbursement through the Health Care FSA. A more detailed list is on the Flex-Plan Services website at flex-plan.com. Items marked with an asterisk are considered over-the-counter medicines or drugs and require a prescription for reimbursement.

- Acne treatment*
- Acupuncture
- Allergy and sinus medication*
- Antacids*
- Anti diarrheal*
- Antibiotic ointment*
- Antifungal foot cream*
- Anti-gas medication*
- Anti-itch cream/gel*
- Antiseptic*
- Asthma treatment*
- Bandages
- Birthing classes or Lamaze
- Blood pressure monitor
- Braces (knee, ankle, wrist)
- Burn cream*
- Chiropractic
- Cold/hot pack
- Cold sore treatment*
- Cold/cough medication*
- Compression stockings
- Contracts/solutions
- Contraceptives
- Copayments
- Copayments
- CPAP machine
- Crutches
- Deductibles
- Dental services
- Diabetic supplies
- Diaper rash ointment*
- Drug addiction treatment
- Ear wax removal kits
- Eye drops
- Eye exams
- Fertility monitor
- Fertility treatment
- First aid supplies
- Flu shots
- Hearing aids and supplies
- Hemorrhoid medication*
- Hormone therapy
- Hospital fees
- Immunizations
- Incontinence supplies
- Individual counseling
- Insect bite treatment*
- Lab work
- Lactose intolerance pills*
- Laser eye surgery
- Laxative*
- Lice treatment products*
- Medical testing devices
- Medical records
- Motion sickness relief*
- Nasal strips
- Naturopathic visits
- Optometrist services
- Orthodontia
- Orthotics
- Oxygen and equipment
- Pain relievers*
- Parasitic treatment*
- Physical exams
- Physical therapy
- Pregnancy test
- Prenatal vitamins
- Prescription drugs
- Prescription glasses
- Reading glasses
- Saline nasal spray
- Smoking cessation products*
- Speech therapy
- Sterilization procedure
- Stool softener*
- Thermometer
- Throat lozenges*
- Vaccinations
- Vision therapy
- Walker
- Wart treatment*
- Wheelchair and repair
- X-ray

INELIGIBLE HEALTH CARE EXPENSES

Following is a partial list of health care expenses **not** eligible for reimbursement through the Health Care FSA. If you have questions about expenses not listed, contact Flex-Plan Services at 425-451-7002 (toll-free: 800-669-FLEX). .

- Airborne
- Books
- Boutique practice fees
- COBRA premiums
- College insurance
- CPR classes
- Electric tooth brush/picks
- Electrolysis/laser hair removal
- Face lift
- Finance changes
- Funeral expenses
- Gender reassignments
- Gym membership
- Hair growth products
- Hair transplant
- Household help
- Hygiene products
- Illegal operations and substances
- Imported OTC items
- Imported prescriptions
- Insurance premiums
- Late fees
- Liposuction
- Marijuana
- Marriage counseling
- Massage chair
- Mattress
- Missed appointment fee
- Teeth Whitening
- Toiletries
- Veneers
- Warranties

ESTIMATING EXPENSES

The following worksheet can help you estimate your eligible health care expenses not covered by your other benefits. Remember, all eligible expenses for you, your IRS dependent spouse or domestic partner and your children through the end of the calendar year in which they turn 26 are reimbursable from your Health Care FSA.

Medical Expenses	Estimated Plan Year Expenses
Copayments	$_____
Deductibles	$_____
Physical Exams	$_____
Prescription Drugs	$_____
Surgical Fees	$_____
X-Ray or Lab Fees	$_____
Other Medical Expenses	$_____
Dental Expenses	
Copayments	$_____
Deductibles	$_____
Dentures	$_____
Examinations	$_____
Orthodontia	$_____
Restorative Work (crowns, caps, bridges)	$_____
Teeth Cleaning	$_____
Other Dental Expenses	$_____
Total Column 1	$_____

Vision Expenses	Estimated Plan Year Expenses
Copayments	$_____
Deductibles	$_____
Eye Examinations	$_____
Laser Eye Surgery	$_____
Prescription Contact Lenses	$_____
Prescription Eyeglasses or Sunglasses	$_____
Other Expenses	
Acupuncture, chiropractors, naturopaths (needs verification)	$_____
Hearing Aids	$_____
Immunization Fees	$_____
Psychiatrist, Psychologist Counseling *	$_____
Chiropractic Care	$_____
Total Column 2	$_____
Total Column 2	$_____

Total Column 1 $ _____ + Total Column 2 $ _____ = Total Estimated Expenses $_____

* Allowed for treatment of specific physical or mental disorder (e.g. depression, alcohol, or drug treatment). A physician's diagnosis is necessary for reimbursement.

MAKING MID-YEAR CHANGES

The election you make when you enroll is effective for the entire plan year. You may only change your election – begin, increase, decrease or stop your contributions – during Open Enrollment, or when you have a qualifying status change. The following are examples of qualifying status changes:

- Change in your legal marital status including marriage, divorce, and death of a spouse, legal separation, or annulment.
- Change in the number of your dependents due to birth, adoption, or placement for adoption, or death of a dependent.
- Ending or starting employment by you, your spouse or dependent or beginning or return from an unpaid leave of absence (including FMLA leave).
- An event that causes a dependent to satisfy or cease to satisfy the requirements for coverage due to age, gain or loss of student status, marriage or any similar circumstances as are provided in the accident or health plan.

You have 31 days from the date of the event to change your FSA election(s). The change you make must be consistent with and on account of your status change. For example, if you adopt a child you can begin or increase contributions to a Health Care FSA (that is consistent with the status change), but you cannot stop or reduce contributions to a current Health Care FSA (that is not consistent). Questions? Please contact your department's human resources representative.

DEBIT CARD OPTION

The health care flexible spending account debit card, the Benny Card, enables you to pay for eligible flexible spending account expenses directly from your health care flexible spending account so you don't have to wait for reimbursement though receipt submittal is still required. The debit card merely provides immediate access to the funds held in your FSA. The IRS requires that each FSA transaction be validated, regardless of the method of payment.

The debit card pays for non-reimbursed out-of-pocket expenses for medical, dental, prescription drug, vision and hearing services and supplies at any merchant who accepts MasterCard such as doctor's offices, dental and vision clinics, hospitals, pharmacies, mail order pharmacy programs, and drug stores.

You may request the debit card by submitting the form to Flex-Plan Services by mail, email or fax. An email address is required for notifying you when receipts are required to be submitted. Please allow 2-3 weeks to receive your card(s) in the mail.

Even if you have a Benny Card, you may continue to submit your itemized receipts and reimbursement form, as you do now, to Flex-Plan Services for reimbursement by check or direct deposit.

FILING A CLAIM

To get reimbursed for health care expenses, use the Reimbursement Request Form at the end of this booklet, copy on the Benefits web site at inweb/personnel/benefits or seattle.gov/personnel/benefits/home.asp, or upload your itemized receipts through the FPS portal using your online account (see page 6). Claims for reimbursement from your spending accounts may be submitted any time during the plan year in which the expenses are incurred or in the first three months of the following year. With the claim form, you must submit a bill or receipt from the provider that gives the following information:

- Name of the provider and – in some cases – the provider's taxpayer identification number
- The date(s) services were provided
- The type of service provided
- Who received the service
- Amount you are responsible to pay

When your Health Care FSA reimbursement request is received and approved, you are reimbursed for your eligible expenses up to the maximum amount you elected, minus any previous reimbursements made during the calendar year. Even if your reimbursement request is greater than your current account balance, you will be reimbursed for the total amount of your request, up to the total Health Care FSA contribution you elected for the plan year. You can file a claim by mail, fax, or upload to the FPS website (see page 6) at:

Flex-Plan Services, Inc.
PO Box 53250
Bellevue, WA 98015-3250
Phone: 425-452-3500; 800-669-FLEX
Fax: 425-451-7002; 800-535-9227
www.flex-plan.com

Requests for reimbursement MUST be submitted before March 31 following the close of the plan year, or you will forfeit any funds remaining in the account.

DIRECT DEPOSIT OF REIMBURSEMENTS

To have your Health or Dependent Care reimbursements deposited directly into your bank account, submit the Direct Deposit/Benny Card Authorization Form to Flex-Plan Services (FPS) after you've enrolled. (Once you start receiving direct deposits from Flex-Plan Services, you do not need to complete another form for subsequent years.)

NOTIFICATION OF CLAIM DENIAL

You will receive a response to your claim within 90 days after your claim is submitted. More time may be required if there are special circumstances. If so, the Plan Administrator will contact you within the 90-day period. This notice will include an explanation as to why extra time is required and the date you can expect a decision. The extension will not exceed an

additional 90 days. If the Plan Administrator fails to notify you within the designated time period, your claim will be considered to have been denied. If all or part of your claim is denied, you will receive written notification explaining the reasons for the denial, a description of any additional information or material needed to complete your claim, an explanation of why the information is necessary and appropriate information about the plan's claims review procedures.

APPEALING A DENIED CLAIM

If your claim is denied and you wish to appeal, you must file your appeal with the Plan Administrator (Flex-Plan Services) within 180 days after you receive the denial. Your appeal should include any additional information that you wish the Plan Administrator to consider. If your appeal is not filed within this 180-day period, you will not be able to appeal your claim.

The Plan Administrator will notify you in writing within 30 days after your appeal is received. If there are special circumstances, more time may be necessary to review your appeal. You may be asked to wait an additional 60 days for a decision. The response time will be extended by reasonable time if necessary. The decision will be final and binding on all parties and will be communicated to you in writing. If you do not receive a written response from the Plan Administrator within the designated time period, your appeal will be considered to have been denied.

IF YOU LEAVE EMPLOYMENT

If you leave employment and do not continue your Health Care FSA under COBRA, your participation in your FSA ends the day you leave employment. You have until March 31 of the following year to submit reimbursement requests for expenses incurred through the date you leave.

You may continue participating in your Health Care FSA after you leave City employment (contributing to the account and requesting reimbursements) through the end of the calendar year as long as you elect to continue your FSA plan under COBRA. You have until March 31 of the following year to submit reimbursement requests for expenses incurred during the calendar year while under COBRA.

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

If you are a regularly appointed full-time or part-time employee and have children (including adopted children, step children, and foster children) under age 13 who qualify as dependents on your federal income tax return; a spouse who is physically or mentally incapable of self-care; or any other person who qualifies as a dependent on your federal income tax return if that person is physically or mentally incapable of self-care, you are eligible to participate.

To qualify as a dependent for federal income tax purposes, an individual generally must be a member of the taxpayer's household, receive more than one-half of his or her total support from the taxpayer, and fall within the class of persons described in Section 152 of the Internal Revenue Code. Children of divorced or separated parents may qualify as tax dependents of the parent who has custody for the greater part of the calendar year. IRS Publication 503, Child and Dependent Care Expenses, contains additional information regarding qualifying persons.

DEPENDENT CARE FSA vs. TAX CREDIT

If you will pay dependent care expenses in 2013, you have two options to save money on taxes:

- Dependent Care FSA – reduces the amount of pay subject to federal income and Social Security taxes.
- Child and Dependent Care Tax Credit – reduces the amount of federal income tax you pay.

The information provided below will assist you in deciding between the Dependent Care FSA and the Child and Dependent Care Tax Credit.

- As your adjusted gross income increases, the tax credit goes down while your federal income and Social Security taxes go up.
- The tax credit allows you to claim only up to $3,000.00 in eligible expenses for one dependent and up to $6,000.00 for two or more dependents.
- Generally, the Dependent Care FSA allows you to contribute up to $5,000.00 regardless of the number of dependents.
- You cannot use the Child and Dependent Care Tax Credit on your tax return for expenses that are reimbursed through Dependent Care FSA; the tax credit is reduced dollar for dollar by the amount you are reimbursed through the Dependent Care FSA.
- If you are married and will be filing a separate return for 2013, but not as head of household, you are ineligible for the Child and Dependent Care Tax Credit. Therefore, the Dependent Care FSA may be the only tax benefit available to you for

dependent care expenses. A maximum annual contribution of $2,500.00 would apply to you in this case.

The size of your tax savings will depend upon several factors, including your income, spouse's income, child's age, amount of dependent care expenses, filing status, and number of personal exemptions.'

Since tax laws are complicated and subject to change, you should re-examine your tax situation every year and consider discussing your situation with a tax specialist. You may need to report on your tax return form 2441 how much was withheld for daycare and who you paid.

ELIGIBLE EXPENSES

In general, you can use the plan to pay dependent care expenses for an eligible dependent so that you can work. Here are more detailed guidelines:

- Your dependent care expenses must be employment related. For instance, you may use the plan to pay for childcare expenses while you work, but you may not use the plan to pay for a caretaker while you go to a movie.

- Eligible expenses include charges for care of an eligible dependent inside or outside of your home, including such things as feeding, administration of medicine, general supervision, and nursery school. (Charges may include household services such as cooking, cleaning, and general housekeeping if they are incidental to care for a qualifying person.)

- Dependent care services may be provided inside your home, in a licensed day care shelter, or in someone else's home.

- For dependents other than your children under age 13, services provided outside your home are reimbursable only if the dependent spends at least eight (8) hours each day in your home.

- Out-of-home care expense must comply with all applicable state and local regulations if the facility provides care for more than six nonresident individuals. (State and local licensing laws may require licensing where care is provided for fewer persons.)

- Services must occur during the plan year (January 1 through December 31), and must be provided while you are employed. If you are married, they must also be provided while your spouse is employed (or if your spouse is a full-time student, while your spouse attends school).

INELIGIBLE EXPENSES

Some dependent care expenses do not qualify for payment through the plan, as follows:

- The cost of schooling for a child in the first grade or above;

- The cost of kindergarten. (The cost of before/after school care is covered.)
- Camp expenses when the child stays overnight;
- Itemized expenses for classes such as dance, gym, swimming, language, etc. If the fee for the class is included in the regular weekly or monthly fee, then the expense is allowable according to the IRS regulations;
- Payments to a person for whom you can claim a dependency exemption for federal income tax purposes;
- Expenses which have been paid from other sources, such as another employer's plan;
- Expenses you pay during the months your spouse has no income. If your spouse is a full-time student or totally disabled, however, special rules apply. These rules are explained under "Estimating Expenses".
- Expenses you pay if you are absent from work due to illness or injury, even if you receive sick pay and continue to be considered an employee, or while on vacation, holiday, or other time off.

For more information about eligible or ineligible expenses, please refer to the tax instructions for filing Federal Income Tax Form 1040 and IRS Publication 503, Child and Dependent Care Expenses at www.irs.gov.

ESTIMATING EXPENSES

To participate in the Dependent Care Flexible Spending Account, you must first estimate the amount of eligible dependent care expenses you expect to incur during the plan year and then calculate your annual salary reduction amount. Your annual salary reduction amount is subject to the following limitations.

- If you are unmarried, the amount of your salary you may contribute to the plan is the lesser of $5,000 or your earned income.
- If you are married, the amount of your salary reduction may not exceed the lesser of your earned income or the earned income of your spouse. In addition, if your spouse is a full-time student or incapable of self-care (disabled), he or she is assumed to have income as follows:
    - If you pay dependent care expenses for one dependent, you may assume that your spouse’s income is $250 per month.
    - If you pay dependent care expenses for two or more dependents, you may assume that your spouse’s income is $500 per month.

- Your spouse's assumed income applies only to the months that he or she is a full-time student or disabled.

- If you are married and will file a joint return, the total amount that you and your spouse may contribute to this plan is $5,000, subject to the above earned income limits.

- If you are married and will file a separate return, but not as head of household, the maximum amount you may contribute to the plan is $2,500. Special rules apply to which spouse may claim dependent care expenses, so be sure to consult your tax advisor.

- If you or your spouse participates in any other dependent care plan during the same calendar year in which you participate in the City of Seattle Dependent Care Flexible Spending Account, the IRS limit is $5,000.00 for all plans combined.

- Further limitations may apply based on your income, your spouse's income, and your filing status. Refer to IRS Publication 503, Child, and Dependent Care Expenses.

Your annual salary reduction amount is divided into equal payroll deductions during the plan year. No deductions will be taken from the third paycheck of the month. These amounts are then deposited into your dependent care account.

The amount of salary reduction you elect should not exceed your estimate because federal tax regulations require you to forfeit any amount not expended for a plan year.

The following worksheet will help you estimate your eligible dependent care expenses:

Estimated Plan Year Expenses	
Babysitter	$
Day Care Center	$
Nursery School	$
After-School Care	$
Day Camp	$
Care for Qualifying Adult	$
Total Estimated Expenses	**$**

MAKING MID-YEAR CHANGES

The election you make when you enroll is effective for the entire plan year. You may only change your election – begin, increase, decrease or stop your contributions – during Open Enrollment, or when you have a qualifying status change. The following are examples of qualifying status changes:

- Change in your legal marital status including marriage, divorce, death of a spouse, legal separation or annulment
- Change in the number of your dependents due to birth, adoption or placement for adoption, or death of a dependent
- Ending or starting employment by you, your spouse or dependent, including a switch between part-time and full-time status, a strike, lockout or beginning or return from an unpaid leave of absence (including FMLA leave) effecting eligibility
- An event that causes a dependent to satisfy or cease to satisfy the requirements for coverage due to age, gain or loss of student status, marriage or any similar circumstances as are provided in the accident or health plan
- Change in the place of residence or work of you, your spouse or dependent
- Significant changes in day care provider's rates (except if relative)
- Change in day care situation that affects the rates (provider change, infant rate to toddler rate)

You have 31 days from the date of the event to change your FSA election(s). The change you make must be consistent with and on account of your status change. For example, if you adopt a child you can begin or increase contributions to a Dependent Care FSA (that is consistent with the status change), but you cannot stop or reduce contributions to a current FSA (that is not consistent). Questions? Please contact your department's human resources representative.

FILING A CLAIM

Copy and use the FSA Claim Form at the end of the plan booklet to get reimbursed for dependent care expenses or use the copy on the City Benefits web site at personnelweb/benefits/home.aspx

Claims for reimbursement from your spending account may be submitted any time during the plan year in which the expenses are incurred, but must be submitted before March 31 following the close of the plan year. With the claim form, you must submit a bill or receipt from the provider that gives the following information:

- Name of the provider and the provider's taxpayer identification number and signature if provider cannot produce a printed receipt from their business
- The date(s) of services were provided
- The type of service provided
- Who received the service

You can file a claim by mail, fax, or upload to the FPS website (see page 6) at:

Flex-Plan Services, LLC
PO Box 53250
Bellevue, WA 98015-3250
Phone: 425-452-3500; 800-669-FLEX
Fax: 425-451-7002; 800-669-FLEX
www.flex-plan.com

When your Dependent Care FSA reimbursement request is received and approved, you are reimbursed for your eligible expenses up to your account balance. If your request is greater than your current account balance, the remainder will be paid to you later, after additional contributions are made to your account.

NOTIFICATION OF CLAIM DENIAL

You will receive a response to your claim within 90 days after your claim is submitted. More time may be required if there are special circumstances. If so, the Plan Administrator will contact you within the 90-day period. This notice will include an explanation as to why extra time is required and the date you can expect a decision. The extension will not exceed an additional 90 days. If the Plan Administrator fails to notify you within the designated time period, your claim will be considered to have been denied.

If all or part of your claim is denied, you will receive written notification explaining the reasons for the denial, a description of any additional information or material needed to complete your claim and an explanation of why the information is necessary and appropriate information about the plan's claims review procedures.

APPEALING A DENIED CLAIM

If your claim is denied and you want to appeal, you must file your appeal with the Plan Administrator within 60 days after you receive the denial. Your appeal should include any additional information that you want the Plan Administrator to consider. If your appeal is not filed within this 60-day period, you will not be able to appeal your claim.

The Plan Administrator will notify you in writing within 60 days after your appeal is received. If there are special circumstances, more time may be necessary to review your appeal. You may be asked to wait an additional 60 days for a decision. The response time will be extended by reasonable time if necessary. The decision will be final and binding on all parties and will be communicated to you in writing. If you do not receive a written response from the Plan Administrator within the designated time period, your appeal will be considered to have been denied.

IF YOU LEAVE EMPLOYMENT

If you leave employment, you may continue submitting reimbursement requests for eligible dependent care expenses incurred through the end of the calendar year in which you terminated. You must submit all requests by March 31 of the following calendar year.

ADDITIONAL ADMINISTRATIVE INFORMATION

CUSTOMER SERVICE

Flex-Plan Services Phone 7:00 am – 5:00 pm PST	Direct: 425-452-3500 Toll Free: 800-669-FLEX
Customer Service Email	flexplan@flex-plan.com
Mailing Address	Flex-Plan Services PO Box 53250 Bellevue, WA 98015-3250
FAX Number	425-451-7002 800-535-9227
Web Site	www.flex-plan.com

FSA FORMS

The following forms are included in this booklet.

- Flexible Spending Account Claim Form
- Benny Card/Direct Deposit Authorization Form
- Flexible Spending Account Change/Termination Form

Remember: You must re-enroll <u>each year</u> at Open Enrollment to continue participating in Flexible Spending Accounts.

CITY OF SEATTLE

Flexible Spending Account Claim Form

FOR PLAN YEAR JANUARY 1, 2013 *through* DECEMBER 31, 2013

Section I – Employee Information

Last Name, First Name	MI	Day Phone	Employee ID
Address	City	St Zip	Email* SEE INFORMATION BELOW
☐ **Address Change**			

Instructions

1. Complete Section I – Employee Information. This form can only be used for services incurred during the plan year shown above. Do not use this form for Benny™ Card transactions.
2. **Do not staple any documentation to claim form, please tape to separate sheet or include loosely in envelope. Do not send originals (all claims are stored electronically and paper copies will be shredded).**
3. Complete Section II – Day Care Claims. Attach proper third-party documentation showing the date(s) of service, cost of service, dependent's name, and provider's name and tax ID or social security number (No cancelled checks, balance forwards, or bank card receipts).
4. Complete Section III – Health Care Claims. Attach proper third-party documentation showing the date(s) of service, type(s) of service and cost (No cancelled checks, balance forwards, or bank card receipts). Itemize all expenses to prevent delays in reimbursement.
5. Complete Section IV - Signing the claim form. Fax or mail a signed claim form, but do not do both. Online claims status is available at www.flex-plan.com. Claims must be submitted at least two (2) full business days prior to the scheduled reimbursement date

Section II – Day Care FSA

Start Date	End Date	Provider's Name, Tax ID/or SSN	Name of Dependent	Age	Cost
See IRC Section 129 for qualifying Day Care expenses or consult your tax advisor for more information.			**Total Day Care FSA Request $**		

Section III – Health Care FSA

Service Dates	Type of Service	Name of Provider	For Whom	Net Cost	Benny Offset? (Y/N)
Did you use your Benny Card for any of these expenses?			❑**No**	❑**Yes**	
See IRC Section 213 for qualifying Health Care expenses or consult a tax advisor for more information.			**Total Health Care FSA Request $**		

Section IV – Signature

To the best of my knowledge my statements on this claim form are complete and true. I understand that I am solely responsible for the sufficiency, accuracy, and veracity of claims and all information related to these claims submitted to my Health Care ("HCFSA") or Day Care Flexible Spending Arrangement ("DCFSA"), and that unless an expense for which payment or reimbursement is claimed is a proper expense under the HCFSA or DCFSA, I may be liable for the payment of all related taxes including federal, state or city income tax on amounts paid from the HCFSA or DCFSA which relate to such expense. I further understand that no day care tax credit is permitted for amounts for which reimbursement is made. I am claiming health care reimbursement for eligible medical care expenses incurred by myself, spouse, and/or dependents during the plan year shown above and certify that these expenses have not been reimbursed under this plan or by any other source and that they will not be reimbursed by any other source or insurance. *By providing an email address, I consent to receive all possible communications regarding the Plan via email. I may withdraw consent at anytime without charge by contacting Flex-Plan by phone, email, or mail. To update your email address contact Flex-Plan by phone, email, or mail. You have the right to receive paper version of an electronic document free of charge. Software requirements will be provided with each electronic document. I hereby authorize my HCFSA and/or DCFSA to be reduced by the amount(s) shown above.

Participant's Signature **X**	Date

Fax completed form and documentation to:
FAX: (425) 451-7002 or toll-free (866) 535-9227

Email:
claims@flex-plan.com

Mail forms and documentation to: Flex-Plan Services, Inc.
PO Box 53250 Bellevue, WA 98015-3250

Customer Service Line: (425) 452-3500 or (800) 669-FLEX Visit our Web site at www.flex-plan.com

2013 Health Care and Dependent Care Claim Form Instructions Bulletin

REQUEST FOR REIMBURSEMENT PROCESS

Prompt claim processing is largely dependent on the submittal of a properly completed *Request for Reimbursement* form (Health Care and Dependent Care (Day Care) Reimbursement). A properly completed form includes:

- ❑ Legible personal information (employee name & current address)
- ❑ Employer Name (when not using a pre-printed form from your Employer)
- ❑ A marked change of address box, if applicable
- ❑ Legible claim description and expense information
- ❑ A legible, itemized statement and/or receipts from your provider
- ❑ An Explanation of Benefits (EOB) from all health insurance carriers
- ❑ Claim total
- ❑ Employee SIGNATURE
- ❑ A separate claim form for each plan year

CLAIM PROCESSING TIMELINES

Properly completed Request for Reimbursement forms received 72 hours before your plans' scheduled check-printing date will be processed in that check run. If your Request for Reimbursement is incomplete, it's processing may be delayed until the matter is resolved.

Please retain a copy of your Request for Reimbursement Form, along with all supporting documentation for your itemized expenses.

CHECK STOP PAYMENT and/or CHECK REISSUE REQUESTS

Flex-Plan Services (FPS) will process check stop payment and/or reissue according to the following guidelines:

- ❑ All stop payment requests will be held for a minimum waiting period of ten business days from the original check release date.
- ❑ Once FPS has placed the stop payment with the financial institution, the reissued check will be held for 2 business days in accordance with the financial institution's requirement.
- ❑ **A $25 processing fee will apply for all stop payment/reissued checks not resulting from a FPS error**
- ❑ FPS will issue a replacement check for a damaged original check only after the original check has been returned to FPS

OTHER HELPFUL HINTS

- ➢ Eligible expenses are determined by the date of service, NOT the date the payment is made to the provider. Therefore, cancelled checks, bank statements, credit card receipts, and provider balance forward statements are not acceptable documentation.
- ➢ A Dependent Care claim may be submitted up to 1 month in advance of services rendered
- ➢ Once the plan year has begun, you may only change your elected annual contribution amount if you have a change in family status (see your Summary Plan Description for more details).
- ➢ IRS rules require that the balance remaining in your reimbursement account (healthcare and/or dependent care) be forfeited at the end of the plan year.

EXAMPLES OF EXPENSES NOT ELIGIBLE FOR REIMBURSEMENT

- ➢ Health Care Spending Account: weight loss programs unless prescribed to treat a specific medical condition, cosmetic surgery, teeth bleaching, missed appointment fees or custodial care (nursing home)
- ➢ Dependent Care Spending Account: overnight camp, diapers, late payment charges and care provided while you or your spouse are not working
- ➢

2013 BENNY CARD / DIRECT DEPOSIT AUTHORIZATION FORM

Employee Information

Last Name, First Name _____ Employee ID _____

Address _____ City _____ St _____ Zip _____

☐ **Address Change**

Email REQUIRED FOR BENNY CARD ISSUANCE _____ DOB (MM-DD-YYYY) _____

Benny Card Enrollment

IMPORTANT: The Benny™ card must be elected each year you wish to utilize it. If you used the card in the prior plan year, you will not receive a new card; your current card will be reloaded. **If you have already elected the card on the current year's enrollment form or during online enrollment then you do not need to complete this form.**

Benny™ FSA Debit Card A debit card that pays for your qualifying medical expenses from the Health Care FSA	There is no cost for you to receive the Benny™ Debit Card. **You must provide an email address to use the Benny™ Debit Card**. By checking **YES** I acknowledge that I have read the entire form and agree to allow my employer to deduct improper Benny Expenses from my wages.

❑ YES, I authorize Flex-Plan Services, Inc. to issue a set of Benny™ debit cards for my Health Care FSA Benefit for this plan year.

X _____ _____
Employee Signature **Date**

Direct Deposit Authorization

IMPORTANT: If your Direct Deposit information was provided when you enrolled this year, there is no need to complete this form. However, if your Direct Deposit information has changed, or if you did not provide Direct Deposit information during enrollment, use this form to elect direct deposit for reimbursements.

Direct Deposit Reimbursements are electronically deposited into your bank account.	❑ Checking **Routing #** _____ ❑ Savings **Account #** _____

This authority will remain in full force and effect until Flex-Plan Services, Inc. has received written notification from me of its termination in such time and in such manner as to afford Flex-Plan Services, Inc. and the banking institution a reasonable opportunity to act on it.

❑ YES, I authorize Flex-Plan Services, Inc. to electronically deposit my FSA reimbursements into the above specified bank account.

X _____ _____
Employee Signature **Date**

Fax completed form and documentation to:
FAX: (425) 451-7002 or toll-free (866) 535-9227

Email:
claims@flex-plan.com

Mail forms and documentation to: Flex-Plan Services, Inc.

Direct Deposit

Rules & Instructions

- All direct deposits will be initiated on the same day as the normal check reimbursement date. Deposits may take up to two (2) business days to appear in the designated account.
- Returned items due to incorrect banking information are assessed a $10.00 fee.

Benny Card

Rules & Instructions

- Please be sure to include an email address above or no cards will be issued.
- You will receive two cards in the mail, both with your name on them. They may be used by yourself and/or your qualifying dependents.
- You must elect the Benny Card for each year you want to use the card. You will not receive a new card; your current card will be reloaded.
- Benny Cards are good for 5 years; at expiry you will automatically receive a new set of cards.
- Benny Cards will be loaded ONLY with the new-year annual election amount and may only be used for expenses that are incurred during the current plan year. If you have unused funds from the previous plan year or if the plan offers a Grace Period, you may not use the Benny Card to claim those funds. You will need to submit a manual claim for reimbursement.

Ineligible Benny Card Expenses

- The IRS provides the following 3 methods for correcting the reimbursement of an ineligible Benny Card Charge. A participant must: a) repay the plan for the amount of the ineligible expense, or b) request the substitution or offset of future claims to repay the plan. If neither option “a” nor “b” is successful the final option illustrated by the IRS permits the employer to deduct the ineligible expense from the participant’s wages or other compensation consistent with federal and state law.
- For example, if you use the card for an ineligible expense the card will be suspended to prevent further use. We will reactivate the card once you reimburse the plan for the amount of the ineligible expense. If you do not reimburse the plan the card will remain suspended. You may still submit claims via fax or mail and, upon request, we will substitute or offset those future claims against the amount of the ineligible expense until the amount of the ineligible expense is repaid. If you do not repay the plan or substitute or offset future claims against the amount of the ineligible expense your employer may withhold the improper payment amount from your wages or other compensation consistent with applicable federal or state law.

Lost or Stolen Benny Card

- Participant will be charged $5.00 for the reissue of any lost, stolen, or otherwise misplaced Benny Card. The fee will be deducted from the participant’s Health Care FSA.

City of Seattle

Flex-Plan Services

2013 FLEXIBLE SPENDING ACCOUNT CHANGE FORM

Employee _____ _____ _____ _____

First Name | Last Name | Employee Number | Plan Year

EMPLOYEE ACTION – Type of Event/Contribution Election

As a participant in the cafeteria plan, I am entitled to revoke my prior benefit election and enter into a new election in the event of certain changes in status events.

I understand that the change in my benefit election must be necessitated by and consistent with the change in status event and that the change must be acceptable under the Regulations issued by the Department of Treasury and/or within 31 days (or 60 days for a new child) of that change.

The effective date for the change actions is the first of the month following the change, subject to payroll deadlines. My monthly contribution will appear on my earnings statement.

Life Status Change - Changes permissible due to these events must be on account of and correspond with the event. Check the reason you are completing the form on Page Two and enter the date of the event and your contribution amount.

Type of Action ☐ Enroll ☐ Change Contribution (increase or decrease) ☐ De-enroll

	Date of event	Current Payroll Contribution	New Payroll Contribution
Health Care	_____ (Mo/Day/Year)	$ _____ Yearly amount	_____ Yearly amount
Dependent Care	_____ (Mo/Day/Year)	$ _____ Yearly amount	_____ Yearly amount

The monthly contribution will be calculated by dividing the annual amount by the number of remaining pay periods in the year.

For Health FSA only – Approved Family Medical Leave (FML)

During my Family Medical Leave without pay:

☐ Cancel my coverage

☐ Continue my coverage. Upon my return, my monthly contribution will be the same as before the leave, except the annual amount will be reduced by the number of contributions missed while on leave.

☐ Continue my coverage. Upon my return, my annual contribution will be the same as before the leave, but I have make-up contributions to remain at the pre-existing level.

Signature

My signature indicates I have read and agree to the "Terms and Conditions" on this form. I certify under penalty of perjury that all of the above information is true to best of my knowledge and, if applicable, that I have experienced the event and/or cost change noted above.

_____ _____

Signature of Employee | Date

Continued on Page 2

Health FSA Life Status Change Events

CHANGE IN MARITAL STATUS
☐ You marry
☐ You marry and either – ▪ you and/or your dependent become eligible under and enroll in your new spouse's own employer's health plan, or ▪ your spouse is enrolled in his or her own employer's health FSA
☐ You lose your legal spouse through death, divorce, legal separation or annulment
☐ You lose your legal spouse through death, divorce, legal separation or annulment and you and/or your dependent lose coverage under your spouse's employer's health plan or health care FSA
GAIN OR LOSS OF A DEPENDENT
☐ You gain an eligible dependent (for example, through birth, adoption or your eligible child moves in with you)
☐ You lose an eligible dependent or a dependent loses eligibility (for example, through death, or when an individual is no longer financially supported by you)
CHANGE IN EMPLOYMENT STATUS
☐ You, your spouse or dependent gains eligibility for and enrolls in own employer's health FSA, or enrolls self and you in own employer's health plan because you/he/she - ▪ starts employment or ▪ has an employment status change
☐ You, your spouse or dependent loses eligibility for own employer's health FSA or health care because you/he/she - ▪ ends employment, or ▪ has an employment status change

Services incurred prior to the change in status event can only be reimbursed to the maximum benefit in place on the date that the service was incurred. It is not available from the new election amount.

Dependant FSA Life Status Change Events

CHANGE IN MARITAL STATUS
☐ You marry and gain a dependent
☐ You marry and your spouse is either not employed, or is enrolled in his or her own employer's dependent care FSA
☐ You lose your spouse through death, divorce, legal separation or annulment and your spouse was enrolled in his or her own employer's dependent care FSA
GAIN OR LOSS OF DEPENDENT
☐ You gain an eligible dependent (for example, through birth, adoption, or your spouse becomes incapable of self-care)
☐ You lose an eligible dependent (for example, through death, a child reaches age 25 or child is no longer a tax dependent)
CHANGE IN EMPLOYMENT STATUS
☐ Your spouse gains eligibility for and enrolls in own employer's dependent care FSA because he/she starts employment, or has an employment status change
☐ Your spouse loses eligibility in own employer's dependent care FSA because eh/she ends employment, or has an employment status change
COST CHANGE (DOES NOT APPLY IF PROVIDER IS YOUR RELATIVE BY BLOOD OR MARRIAGE)
☐ Your dependent care provider increase the cost of service
☐ There is a decrease in provider's cost
CHANGE IN PROVIDER OR COVERAGE
☐ You change dependent care providers
☐ Your spouse starts employment
☐ Your spouse ends employment
☐ There is a reduction in hours or cessation of dependent care (for example, a child starts attending school)
☐ You change (in whole or in part) from paid care to no care or free care (for example, free care by a neighbor, relative or for state-paid care
☐ You change (in whole or in part) from free/no care to paid care
☐ You or your spouse changes work schedules, which creates changes or eliminates need for dependent care
☐ Your spouse who is not employed or looking for employment becomes a full-time student, or becomes incapable of self care
☐ Your spouse who is not employed or looking for employment is no longer a full-time student, or is no longer incapable of self care

Please Forward this Form to the Human Resource Representative in <u>Your Department</u>

EMPLOYER USE ONLY COMPLETE BEFORE SENDING TO Flex-Plan Services

TERMINATIONS & LEAVES

Date of Termination/Leave _____ Last Pay Period Contribution Date _____

Date of Return to Work _____ First Contribution Date Upon Return _____

_____ _____

Employer Authorized Signature Total YTD Contribution